

# Let's just do what we must



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## Central Message

Surgeons must know what to do to maximize patients' compliance to adjuvant treatments.

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The excellent editorial by Kruser and colleagues<sup>1</sup> about the article by Sun and colleagues<sup>2</sup> is rightfully centered on the postoperative options for N2 disease and the outcome differences noted when occult N2 is treated compared with N2 identified at preoperative staging. The analysis of the literature shows that, irrespective of the N2 subsets, mediastinal nodal involvement carries a significant risk for distant recurrence.<sup>1</sup> Conversely, the efficacy of preoperative staging predicts the likelihood of mediastinal local recurrence after surgical resection.<sup>1</sup> Despite the presence of specific guidelines,<sup>3,4</sup> the adoption and completeness of both preoperative staging and intraoperative mediastinal nodal dissection may vary according to geographic areas, institutions, and individual surgeons.<sup>5</sup> One example for all is the different approach to preoperatively identified single station N2, which in many reported series is associated with a favorable prognostic outlook after primary resection.<sup>5</sup> However, the common denominator of an oncologically acceptable lung resection remains the performance of a thorough lymphadenectomy with nodal sampling or a complete nodal dissection. Although the impact of either modality on overall survival was not proven in American College of Surgery Oncology Group Z0030, the improved yield in terms of mediastinal staging represents the ground for an optimal choice for possible adjuvant treatments.<sup>6</sup> Liang and associates<sup>7</sup> recently attempted to identify the threshold of the number of lymph nodes to be removed during surgery associated with precise staging and long-term survival. Data from 5706 patients were obtained from a Chinese multi-institutional registry and validated by 38,806 patients from the US SEER database.<sup>7</sup> The authors concluded that, after adjusting for confounders, the greater the number of nodes removed at lung surgery the more precise was postoperative staging, as well as better overall survival in both N0 and N+ disease.<sup>7</sup> In particular, the number of lymph nodes representing the cutoff number to define the quality of the lymphadenectomy was 16; this number originated from the sum of lymph nodes removed intraoperatively by the

surgeon added to the ones identified by the pathologist postoperatively.<sup>7</sup> In the quest for tailoring our surgical procedure to the individual patient who may be subjected to adjuvant treatments, we currently have sufficient evidence to select the parenchymal extent of the resection, and more information will come from the forthcoming trials of lobectomy compared with sublobar resections.<sup>8,9</sup> In this setting, it is a matter of debate whether the preferred approach should be through video-assisted thoracic surgery,<sup>10-12</sup> but the reduced surgical time, intraoperative blood loss, chest drain, and length of hospital stay are appealing and solid arguments in favor of thoracoscopy.<sup>13</sup> In addition, Enhanced Recovery After Surgery protocols are meant to ensure prompt recovery after surgery, thereby further contributing to the compliance to chemotherapy.<sup>14</sup>

Surgery retains a definite role in managing patients with N2 non-small cell lung cancer,<sup>15</sup> and we have the unique opportunity to modulate indications and techniques to fit the patients' potential needs for postoperative treatments.<sup>7,8,16</sup> It is just a matter of doing what we must.

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